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105TH CONGRESS
1ST SESSION

H. R. 1679

To amend the Public Health Service Act to provide for the establishment at the National Heart, Lung, and Blood Institute of a program regarding lifesaving interventions for individuals who experience cardiac arrest, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 1997

Mr. STEARNS (for himself, Mr. ABERCROMBIE, Mr. BACHUS, Mr. BARRETT of Wisconsin, Mr. BOUCHER, Mr. BURR of North Carolina, Mr. CALVERT, Mr. CANADY of Florida, Ms. CARSON, Mr. CASTLE, Mr. CLEMENT, Mr. COYNE, Mr. DAVIS of Virginia, Mr. DEFAZIO, Mr. DELLUMS, Mr. DUNCAN, Mr. ENGLISH of Pennsylvania, Mr. FATTAH, Mr. FOLEY, Mr. FRANK of Massachusetts, Mr. FROST, Mr. GALLEGLY, Mr. GEKAS, Mr. GOODLING, Ms. CHRISTIAN-GREEN, Mr. HASTINGS of Florida, Mr. HILLIARD, Mr. KLINK, Mr. LEACH, Mr. MCDERMOTT, Ms. MCKINNEY, Mr. MASCARA, Mr. MEEHAN, Mrs. MINK of Hawaii, Mr. MORAN of Virginia, Mr. OLVER, Mr. PALLONE, Mr. PAYNE, Mr. PETERSON of Pennsylvania, Ms. RIVERS, Mr. SCHUMER, Mr. SHAYS, Mr. TOWNS, Mr. WALSH, Mr. WAXMAN, and Mr. WELDON of Pennsylvania) introduced the following bill; which was referred to the Committee on Commerce

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A BILL

To amend the Public Health Service Act to provide for the establishment at the National Heart, Lung, and Blood Institute of a program regarding lifesaving interventions for individuals who experience cardiac arrest, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Cardiac Arrest Survival Act''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Each year more than 350,000 adults suffer cardiac arrest, usually away from a hospital. More than 95 percent of them will die, in many cases, because lifesaving defibrillators arrive on the scene too late, if at all.

(2) These cardiac arrest deaths occur primarily from occult underlying heart disease and from drownings, allergic or sensitivity reactions, or electrical shocks.

(3) Survival from cardiac arrest requires successful early implementation of a chain of events—the chain of survival which begins when the person sustains a cardiac arrest and continues until the person arrives at the hospital.

(4) A successful chain of survival requires the first person on the scene to take rapid and simple initial steps to care for the patient and to assure the patient promptly enters the emergency medical services system.

(5) The first persons on the scene when an arrest occurs are typically lay persons who are friends

or family of the victim, fire services, public safety personnel, basic life support emergency medical services providers, teachers, coaches, and supervisors of sports or other extracurricular activities, providers of day care, schoolbus drivers, lifeguards, attendants at public gatherings, coworkers, and other leaders within the community.

(6) A coordinated Federal response is necessary to ensure that appropriate and timely lifesaving interventions are provided to persons sustaining nontraumatic cardiac arrest. The Federal response should include, but not be limited to—

(A) significantly expanded research concerning the efficacy of various methods of providing immediate out-of-hospital lifesaving interventions to the nontraumatic cardiac arrest patient;

(B) the development of research-based, nationally uniform, easily learned and well retained model core educational content concerning the use of such lifesaving interventions by health care professionals, allied health personnel, emergency medical services personnel, public safety personnel, and other persons who are

likely to arrive immediately at the scene of a sudden cardiac arrest;

(C) an identification of the legal, political, financial, and other barriers to implementing these lifesaving interventions; and

(D) the development of model State legislation to reduce identified barriers and to enhance each State's response to this significant problem.

SEC. 3. NATIONAL INSTITUTES OF HEALTH MODEL PROGRAM ON THE FIRST LINKS IN THE CHAIN OF SURVIVAL.

Section 421 of the Public Health Service Act (42 U.S.C. 285b–3) is amended by adding at the end the following subsection:

''(c) Programs under subsection (a)(1)(E) (relating to emergency medical services and preventive, diagnostic, therapeutic, and rehabilitative approaches) shall include programs for the following:

''(1) The development and dissemination, in coordination with the emergency services guidelines promulgated under section 402(a) of title 23, United States Code, by the Associate Administrator for Traffic Safety Programs, Department of Transportation, of a core content for a model State training

program applicable to cardiac arrest for inclusion in appropriate current emergency medical services educational curricula and training programs that address lifesaving interventions, including cardiopulmonary resuscitation. The core content of such program—

''(A) may be used by health care professionals, allied health personnel, emergency medical services personnel, public safety personnel, and any other persons who are likely to arrive immediately at the scene of a sudden cardiac arrest (in this subsection referred to as 'cardiac arrest care providers') to provide lifesaving interventions, including cardiopulmonary resuscitation;

''(B) shall include age-specific criteria for the use of particular techniques, which shall include infants and children; and

''(C) shall be reevaluated as additional interventions are shown to be effective.

''(2) The operation of a demonstration project to provide training in such core content for cardiac arrest care providers.

''(3) The definition and identification of cardiac arrest care providers, by personal relationship, expo-

sure to arrest or trauma, occupation (including health professionals), or otherwise, who could provide benefit to victims of out-of-hospital arrest by comprehension of such core content.

''(4) The establishment of criteria for completion and comprehension of such core content, including consideration of inclusion in health and safety educational curricula.

''(5) The identification and development of equipment and supplies that should be accessible to cardiac arrest care providers to permit lifesaving interventions by preplacement of such equipment in appropriate locations.

''(6) The development of model State legislation (or Federal legislation applicable to Federal territories, facilities, and employees) in cooperation with the Attorney General, which model legislation shall be developed in accordance with the following:

''(A) The purpose of the model legislation shall be to ensure—

''(i) access to emergency medical services through consideration of a requirement for public placement of lifesaving equipment; and

''(ii) good samaritan immunity for cardiac arrest care providers; those involved with the instruction of the training programs; and owners and managers of property where equipment is placed.

''(B) In the development of the model legislation, there shall be consideration of requirements for training in the core content and use of lifesaving equipment for State licensure or credentialing of health professionals or other licensed occupations or employment of other individuals who may be defined as cardiac arrest care providers under paragraph (3).

''(7) The development of a national database for reporting and collecting information relating to the incidence of cardiac arrest, the circumstances surrounding such arrests, the rate of survival, the effect of age, and whether interventions, including cardiac arrest care provider interventions, or other aspects of the chain of survival, improve the rate of survival.

''(8) The publication of a biennial public report summarizing progress in improving care to the cardiac arrest patient.''.

SEC. 4. COMMISSION ON CARDIAC ARREST SURVIVAL.

(a) ESTABLISHMENT.—There shall be established as an independent agency within the executive branch a commission to be known as the Commission on Cardiac Arrest Survival (in this section referred to as the ''Commission'').

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 15 members appointed in accordance with paragraph (2), and the ex offico members designated in paragraph (3).

(2) APPOINTING OFFICIALS; EXPERTISE REQUIREMENTS.—

(A) Of the members appointed to the Commission pursuant to paragraph (1)—

(i) five shall be appointed by the President;

(ii) five shall be appointed by the President Pro Tempore of the Senate, after consultation with the Minority Leader of the Senate; and

(iii) five shall be appointed by the Speaker of the House of Representatives, after consultation with the Minority Leader of the House.

(B) The individuals appointed to the Commission under subparagraph (A) shall collec-

tively have expertise and experience in the following areas: Emergency medical care; pediatric emergency medicine; cardiology; State and local emergency medical services; delivery of State health services; public safety; trauma; public buildings or governmental facilities management; epidemiology; lifesaving equipment design and manufacture; development of model State legislation; human factors engineering; and professional and public education. At least three of the members shall be qualified by scientific training and experience to evaluate the design or conduct of, and data derived from, clinical and educational research in the risks and benefits of resuscitative modalities.

(3) EX OFFICIO MEMBERS.—The membership of the Commission shall include ex officio members from the following agencies: The National Institutes of Health, Department of Health and Human Services; the Department of Education; the National Highway Traffic Safety Administration, Department of Transportation; the General Services Administration; the Department of Defense; and the Department of Justice.

(c) FUNCTION OF THE COMMISSION .—The Commission shall, in consultation with the National Heart, Lung, and Blood Institute, evaluate and provide recommendations on effective methods to increase survival from cardiac arrest. Such recommendations may include recommendations on implementation of this Act, further studies on emergency medical systems or other modalities for early intervention in the chain of survival, or further legislation to improve access to cardiac arrest survival modalities.

(d) REPORTS AND RECOMMENDATIONS.—Not later than 18 months after the date of the enactment of this Act, or during the interim when the Commission believes necessary, the Commission shall prepare and submit to the President and to the Congress a final report.

(e) ADMINISTRATIVE POWERS OF THE COMMISSION.—The Commission may hold hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purpose of this section. The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

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